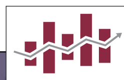

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CALIFORNIA KIDS LOSE EMPLOYMENT-BASED COVERAGE

The impact on the community, business, and the public insurance system

BY ELISE GOULD

Children throughout the country have worsening access to employment-based coverage over the last few years. Children in California are no exception. For many years, workers and their families have relied on employer-provided health insurance. By 2006, only 51.9% of children under 18 in California had such coverage, down 6.5 percentage points from 58.4% in 2000. Young children (those under 6) experienced similar declines in coverage, dropping from 57.6% in 2000 to 51.8% in 2006. While some children get picked up by the public insurance safety net, others simply become uninsured.

It is this harsh reality that has led policy makers at the state and federal levels, as well as prominent presidential candidates, to propose large-scale changes. Again, California is no exception. But unless those changes are adopted, then the over 1.2 million children in California who were left without any coverage in 2006 (and the many more with inadequate coverage) will remain at risk.

Losses in employer-provided health insurance among kids have serious consequences for the children themselves, families, communities, businesses, and the public insurance system. This Briefing Paper documents the ways in which children without employment-based coverage affect those around them, and it provides further evidence for the need for important legislative changes in California and the United States as a whole.

The first section outlines the state of employer-provided health insurance for kids in California and illustrates recent trends in coverage across various sub-populations. Such an analysis highlights the strengths, and more importantly the *weaknesses* of the current system, and points to the populations who have traditionally been left out and thus need to

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be targeted in future policy decisions. This paper then examines the effects fewer insured children have on the community, businesses, and the public insurance system. It is important to understand the widespread effects uninsurance among children has on those besides themselves and their families. Their delay in treatment, lack of disease management, and use of emergency rooms ultimately are detrimental to community and schools, working families and through them business productivity, and the budgets of the public insurance system. If fully funded and implemented effectively, these public systems can provide as good as, and in some cases even more efficient than the employment-based system. This report concludes by addressing specific policy prescriptions that can help ameliorate these problems.

What are the trends in employment-based coverage?

Nearly 5 million children in California, or 51.9% of the under 18 population, had employment provided health insurance in 2006. Data from the March Current Population Survey (CPS) allow an analysis of children by race, nativity, education of family head, and family income from 2000 to 2006.[1] These results are shown in **Table 1** below.

White, non-Hispanic children are more likely to have employment-based coverage than any other race or ethnic group. Their coverage rates are 64.8% compared with 47.4% for black children and 38.9% for Hispanic children. Each of these groups, however, had lower rates of coverage in 2006 than in 2000, with white children displaying the highest

TABLE 1

Employer-provided health insurance, California, children age 17 and under, 2000-06

	Percent with coverage		*Change*
	2000	**2006**	**2000-06**
All under 18	58.4%	51.9%	-6.5
Under 6	57.6%	51.8%	-5.8
Race			
White, non-Hisp.	74.5%	64.8%	-9.6
Black	55.2	47.4	-7.8
Hispanic	42.3	38.9	-3.4
Other	65.4	68.8	3.3
Nativity			
Native	60.4%	53.5%	-6.9
Foreign born	36.6%	32.3%	-4.3
Education of family head			
Less than H.S.	31.9%	24.6%	-7.3
High school	57.1	47.4	-9.7
Some college	69.1	60.2	-8.9
College	80.8	77.1	-3.7
Post-college	86.9	77.4	-9.5
Family income fifth			
Lowest	20.5%	14.1%	-6.4
Second	40.3	35.0	-5.3
Middle	63.8	57.2	-6.7
Fourth	80.8	71.6	-9.1
Highest	87.0	81.9	-5.1

SOURCE: Author's analysis of the March Current Population Survey, 2001-07.

losses in coverage, falling 9.6 percentage points. Native-born children are almost twice as likely to have employment-based coverage as foreign-born children (53.5% versus 32.3%). Both groups experienced losses in coverage in excess of 4 percentage points.

Table 1 also provides insight into the role education plays in children's likelihood of coverage. Because their own education is not complete and the head of the family is likely to be the one providing the insurance for the children, the education level attained by the family head is more informative. The increased likelihood of a child being covered is positively related to increased educational attainment: only about one-fourth of kids in families headed by someone with less than a high school degree are covered, where as over three-fourths of kids in families headed by someone with at least a college degree are covered. This is larger than a three-fold increase in the likelihood of coverage. The table shows a 47.4% coverage rate for children in a family headed by someone with a high school degree, and a 60.2% coverage rate if the household head has some college experience.

Similar to educational attainment, family income plays a vital role in predicting the likelihood of employer-provided health insurance.[2] Inequality in employment-based coverage is rather stark by income group. Those at the top of the income scale are nearly six times more likely to have coverage than those at the bottom. Only 14.1% of children in the lowest 20% of the income scale have coverage, compared with 81.9% of those in the highest income fifth. In addition, while both groups experienced large declines, this disparity has increased over time as the lowest groups experienced a decline of 6.4 percentage points from 2000 to 2006, and the highest group experienced a decline of 5.1 percentage points.

Although the coverage rates of children in the upper-middle fifth of the income scale (i.e., the upper 60-80%) were five times higher than those in the lowest fifth (0-20%), their coverage rates still fell a shocking 9.1 percentage points from 2000 to 2006. The substantial decline in coverage across the income scale clearly points to the widespread erosion in employment-based coverage, providing further evidence that this type of coverage can no longer be relied upon, not even by families making well-above median income. These facts alone make the case for the need for public intervention to fill in the gaps for children higher up the income scale. It also underscores the fact that employers are not dropping coverage in response to public coverage expansions. It is the labor market, not state health policy, that is leading to these dramatic declines in employment-based coverage among the higher-income children.

Overall, about half of all children in California are receiving health coverage through employers. Those who are white, native born, from higher-educated or higher-income families are more likely to have access to employment-based coverage than those who are not. The most severe weaknesses in the system are among those who are Hispanic, foreign born, from less-educated and lower-income families. While all groups of children experienced declines in coverage from 2000 to 2006, for these children, access to workplace coverage is the bleakest.

To better understand the compounding of these negative factors on the likelihood of receiving employment-based coverage, it is instructive to think about individual profiles of children. Only 14.2% of foreign-born, Hispanic children with parents with a high school degree or less had employer-provided health insurance in 2006. Contrasting these children to native-born, white children with parents with a college degree or more, the differences are even starker. These white kids had coverage rates of 75.6% in 2006, or greater than five times the rate of the former group. The declines for the former group were 8.8 percentage points from 2000 to 2006, compared with 11.2 percentage points for the latter group. Clearly, the declines in coverage are widespread, but the inequality is glaring, with some children left completely out of the employment-based health insurance system.

The consequences of fewer children receiving employment-based health coverage

Losses in employer-provided coverage have implications for children, their families, and their communities. Lost coverage for children also affects businesses and the public insurance system. The effects range from poorer health outcomes and higher family costs to lower business productivity and higher taxpayer costs.

When an employer drops family coverage, a child must switch insurance types or become uninsured. If a child becomes uninsured, the family is put at risk for higher sporadic costs and possibly bankruptcy. In some cases, the child who loses employment-based coverage may be able to switch to non-group private coverage, often at a higher cost to the family. In other cases, when eligible, a child may take up public coverage, giving them important access to health care when the employment-based system left them behind. Unfortunately, many children face a spell of uninsurance rather than immediately taking up an alternative form of coverage. Evidence on usage of health care among the sporadically insured suggests that they behave more like the uninsured than those with a constant source of insurance (Collins et al. 2007).

How the decline in insured children affects the community

Insurance plays an invaluable role in providing children access to care. Without this important care, children experience the burden of health services delayed, including untreated illnesses, the higher incidence of health problems, and future financial risks placed on the family. When a family cannot pay or a child goes without treatment, the community must pick up the tab in the form of charity care and the cost of hospitalizations that could have been otherwise avoided by preventive care or early detection and treatment for health problems. The community has the burden of caring for children without necessary immunizations or treatment for communicable diseases, not to mention the costs incurred by their peers exposed to these illnesses. The community also has to pay for higher special education investments and loss of future earnings and productivity when uninsured children do not receive the care they need.

It has been well-documented that the uninsured are less likely to receive medical care than those with insurance. Lower medical care usage, from prevention to treatment, has been shown to have adverse effects on health (IOM 2002a). Lack of insurance has dire consequences for children with and without serious illnesses or chronic conditions. After accounting for differences in race, ethnicity, family income, and health status, uninsured children are less likely to have a usual source of care or get routine well-child care; less likely to get health care when they need it; and use medical and dental services less frequently than insured children (IOM 2002b). The quality of care received by uninsured children is substantially less than that received by insured children. One study finds that uninsured children with asthma received significantly worse care than that received by insured children (Ferris et al. 2001).

Uninsured children are more likely to delay necessary care, risking more serious illness and incurring otherwise avoidable hospitalizations. Having a usual source of care could serve to detect routine conditions such as asthma, which can be treated at a doctor's office instead of an emergency room, for less cost and before the illness becomes as severe. Care in emergency rooms or other safety net providers is often more costly than it would have been if uninsured children had received adequate treatment earlier. The average cost of an avoidable hospital stay in 2006 was approximately $3,885.[3]

Similar to children without serious health problems, uninsured children with serious illnesses or special needs are more likely than insured children to be without a usual source of care, to have gone without seeing a doctor in the last 12 months, and to be unable to get needed medical, dental, vision, and mental health care and prescriptions (IOM 2002a). Uninsured individuals who receive an unexpected illness or injury are less likely to obtain medical care and are more likely to report worse health status in the period following the new health problem than those with health insurance (Hadley 2007). In the worst cases of delayed care and the failure to reach a hospital or receive appropriate specialized care, uninsured children have a greater risk of dying than insured children (IOM 2002a).

While they seek care less, families with uninsured children have higher health expenditures, on average, as a proportion of income than insured families. Those receiving medical care often find themselves with large out-of-pocket liabilities. Since uninsured kids are more likely to be in low-income families, these high costs place an undue burden on their families' budgets, reducing money available for other necessities. Given this hardship, it is not surprising that medical costs are a leading factor in over half of all personal bankruptcy filings (Himmelstein, Warren, Thorne, and Woolhandler

2005). While these are extreme hardship for families without coverage, the remaining costs of uncompensated care are largely borne by the community through higher taxes to pay for subsidies to hospitals and clinics (IOM 2004).

Uninsured children lack routine care that could detect conditions such as ear infections, iron deficiency anemia, and lead poisoning. If left untreated, these conditions have serious ramifications on a child's language development, performance in school, and overall intellectual ability. Iron deficiency anemia has been linked to mental retardation and poor school performance (Dallman et al. 1984; Lozoff et al. 1998). Extensive research has demonstrated that elevated lead levels in the blood cause significant declines in children's measured I.Q. (Canfield et al. 2003). Each of these take a toll on the community in the form of higher necessary investments in targeted programming and special education.

Lack of prenatal care due to a mother's uninsured status also has negative implications for the children, family, and community. Health insurance coverage increases timely initiation of prenatal care, which improves birthweight (Hadley 2002; Rosenzweig and Schultz 1983). Extensive research finds a connection between low birthweight children and the future need for special education (Hadley 2002). Low birthweight and smaller head circumference is not only associated with lower I.Q., but also behavioral problems (Rothstein 2004). This combination of factors further burdens school systems and, in turn, the community. Money going toward these targeted programs could have been spent elsewhere, and the cost of providing insurance to these kids and their mothers is negligible compared to the costs to society later.

In the short run, poor health undermines a child's achievement in school. Untreated vision, hearing, and oral health problems can all cause distractions from learning (Rothstein 2004). Improvements in health lead to better outcomes at school, including paying attention in class and keeping up in school activities (Brown 2004). In the long run, better health improves future prospects and increases earnings, which benefits both the future adults and their communities in the form of a better economy and higher government revenues (Hadley 2002).

How the decline in children receiving employment-based health coverage affects business

Employers have strong incentives to offer family health insurance coverage to their workforce. The productivity of any firm depends on the quality of its employees. A high-quality job, particularly one that offers family health benefits, will better attract and retain more productive employees, will reduce absenteeism and turnover, and will raise productivity through improved morale and worker loyalty. Furthermore, family coverage reduces the possibility of children spreading sickness and disease to their parents and then to co-workers, causing overall declines in productivity. And because insured children receive more consistent health care, parents also need to take less time off of work to care for them, again improving work productivity.

Firms may use health insurance—both individual and dependent coverage—as a recruitment tool. These firms have a greater ability to attract and keep the best workers by offering generous family health benefits. It is essential for firms to recruit and retain high-quality workers, and they may find that these benefits are even more valuable to workers with children. Workers with children may anticipate establishing a long-term employment relationship (O'Brien 2003). In addition, these benefits are enticing to less-healthy and healthy workers alike. Simply keeping the parents healthy is extremely valuable as health affects individual's economic performance on the job (Currie and Madrian 1999).

An offer of affordable, high-quality family coverage can reduce absenteeism and turnover, leading to higher productivity. According to a survey of employees, employer-provided insurance was by far the most important factor in a worker's decision to stay in a job (Duchon et al. 2000). Job lock occurs when workers stay in jobs they might otherwise leave to start their own business or change careers because of the benefits offered. As fewer firms offer family coverage, market inefficiencies due to job lock may be exacerbated. In the current workplace environment, workers will be even less likely to seek employment elsewhere to keep their valuable health benefits.

Without this valuable workplace benefit, parents often find that the financial consequences of having an uninsured child with a serious illness can quickly exhaust the additional wages that may be provided to workers not offered

employment-based health coverage. In addition to being a financial hardship, this can increase stress and the worry involved that may reduce productivity even further (O'Brien 2003).

Employees prefer receiving their health insurance through the workplace rather than via the private market. They receive tax savings from receiving health insurance instead of wages, and they save money on their premiums through "risk pooling" because it is often cheaper for employees to get high-quality insurance for themselves and their children through the workplace. This benefit is even more valuable for families and families with sick children who have an especially hard time securing adequate coverage in the private market. Because of workers preferences, employers may find it more profitable to offer a compensation package composed of both wages and health insurance than providing wages alone (O'Brien 2003).

A survey of small employers found that the majority of employers reported that offering health benefits affected recruitment, helped retain employees, improved employees' attitudes and performance, improved the health of employees, and reduced absenteeism (EBRI 2000). Aside from these benefits, employers have an interest in reducing the numbers of uninsured children overall. Research has shown that the costs of the uninsured are picked up by businesses and their employees in the form of higher premiums for their insurance (Fronstin 2000).

TABLE 2

Medicaid and SCHIP coverage, California, children age 17 and under, 2000-06

	Percent with coverage		*Change*
	2000	**2006**	**2000-06**
All under 18	25.6%	30.7%	5.1
Under 6	28.5%	35.7%	7.2
Race			
White, non-Hisp.	14.1%	16.8%	2.7
Black	36.6	37.9	1.2
Hispanic	36.5	42.9	6.4
Other	18.1	18.1	0.0
Nativity			
Native	25.6%	30.3%	4.6
Foreign born	24.6%	36.1%	11.5
Education of family head			
Less than H.S.	46.8%	57.6%	10.8
High school	28.5	33.8	5.2
Some college	19.0	25.3	6.4
College	6.2	8.4	2.2
Post-college	3.6	4.5	0.9
Family income fifth			
Lowest	54.5%	65.1%	10.7
Second	36.6	48.9	12.3
Middle	15.0	23.8	8.8
Fourth	7.9	10.9	3.0
Highest	1.8	4.7	2.9

SOURCE: Author's analysis of the March Current Population Survey, 2001-07.

How the decline in children receiving employer-based health coverage affects the public health insurance system

This section documents the trends in coverage for California's children by family income level, ethnicity, and education level, closely scrutinizing how public insurance is picking up the slack in employer-provided coverage and demonstrating how improved access to public insurance in the nation as a whole has helped improve children's health.

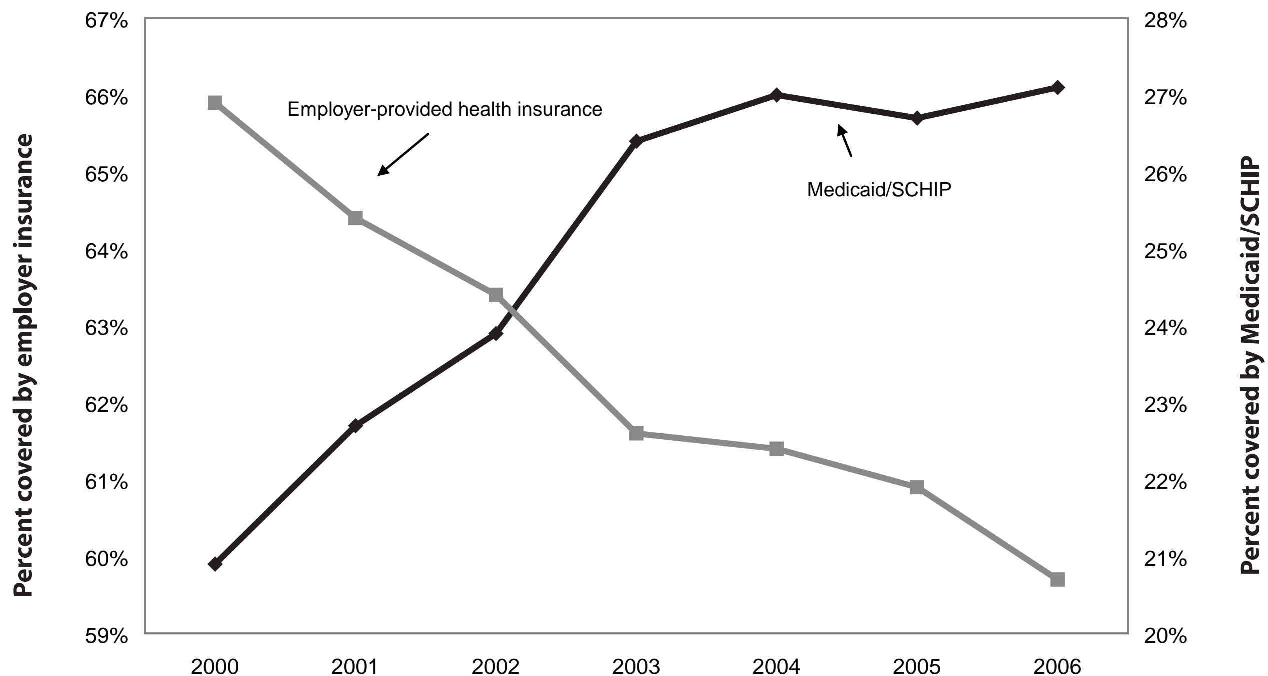
Table 2 shows the coverage rates for children in Medi-Cal, or Medicaid, and Healthy Families, or SCHIP, in California. Close to 3 million children in California are on one of these public insurance plans in 2006, up a half million since 2000. About 30.7% of children under 18 and just over one-third of kids under six are enrolled in public insurance in California. This rate has gone up in the previous six years, most significantly for the younger population.

Black and Hispanic children are more than twice as likely to be enrolled than white children, and this gap has continued to widen for Hispanics from 2000 to 2006. Similarly, foreign-born children are more likely to have public coverage, and this shift increased dramatically during the recent period.

Children of parents with less than a high school education are over eight times more likely to be on public insurance than their counterparts with parents who have at least a college degree. A third of children with parents with a high school education and a quarter of children with parents with some college are enrolled in Medi-Cal or Healthy Families.

As children lost employment-based coverage since 2000, they experienced overall gains in public coverage, a trend seen throughout the country. **Figure A** below demonstrates how public coverage helped keep more children from becoming uninsured as employer-provided health insurance fell. These results do not identify whether individual children switched from private to public coverage, but rather that, over the last six years, fewer children are in the employment-based system and more children are in the public system. In fact, children may move from employer-provided coverage

FIGURE A



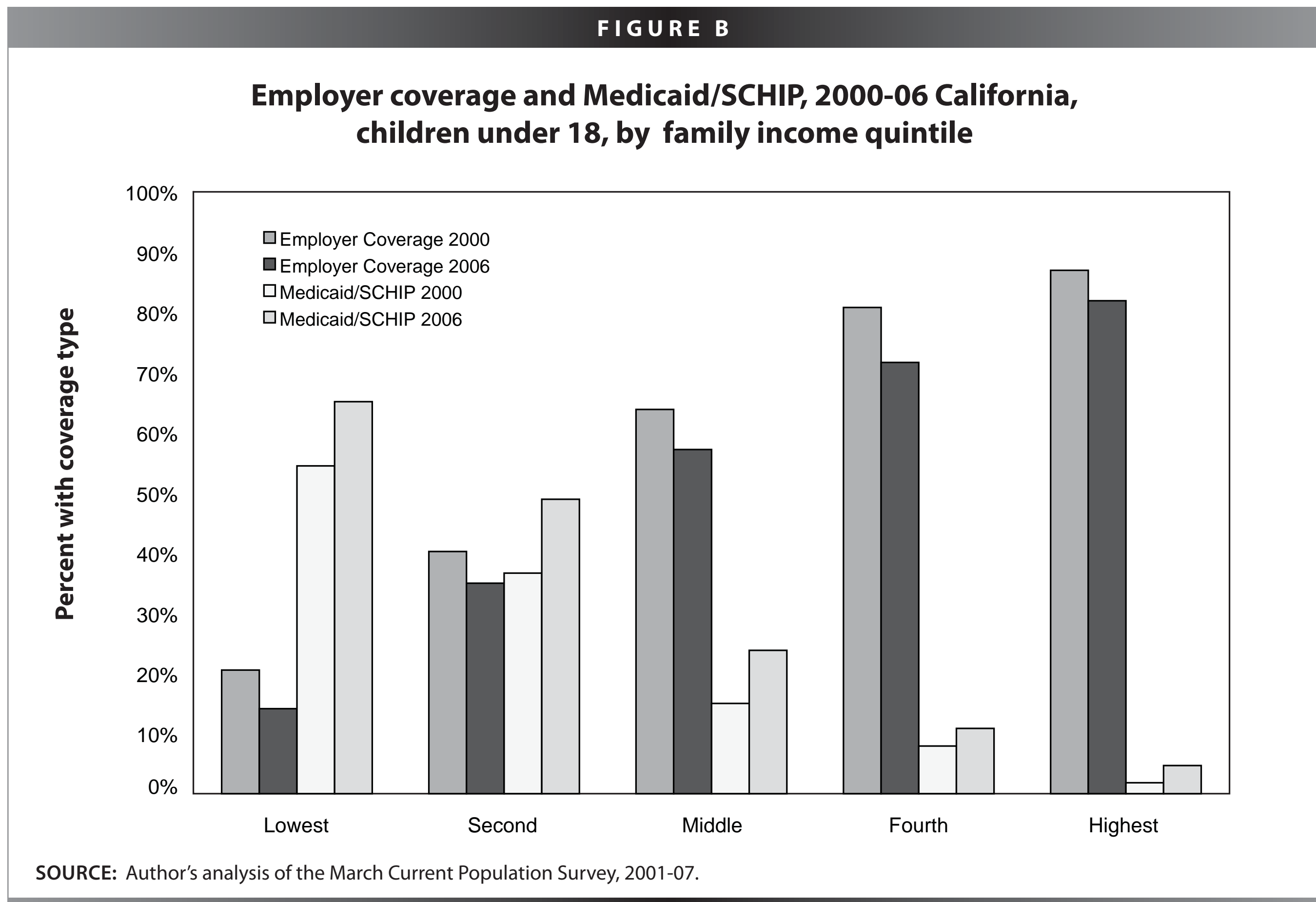
SOURCE: Author's analysis of the March Current Population Survey, 2001-07.

to uninsured as others move from being uninsured to public coverage. With the exception of the drop in public coverage in 2005, recent increases in public coverage for children is the only thing that has allowed the continued decline in the percent of uninsured kids over the past few years when employment-based coverage has fallen.

As stated previously, these results *do not* indicate that public coverage is causing employment-based insurance to drop. In fact, both are signals of a weak labor market, as fewer employers offer affordable coverage and more kids fall into the eligible range for public insurance.

While the data in Figure A are for the United States as a whole, similar trends were experienced in California.[4] What this picture masks is the underlying differences in health insurance rates by income. **Figure B** demonstrates the differences in trends in employer-provided and public insurance by household income level (measured in fifths).

FIGURE B



SOURCE: Author's analysis of the March Current Population Survey, 2001-07.

The figure reveals several important phenomena at play. First, it is clear that, as income increases, access to the employment-based system increases. Similarly, as income falls, access and enrollment in public insurance increases. Second, employer coverage has been falling for every income group from 2000 to 2006 as public insurance has increased for every income group during the same period. Third, for those with the lowest income, public insurance is far more important as a provider of coverage to children than the employment-based system. And, for the second-lowest income quintile (or fifth), this period is marked by a shift in the predominant form of insurance from private to public. For the highest income groups, public insurance plays a tiny role in insuring children.

It is clear from these figures that the declines in employment-based coverage are strengthening our need for and reliance on a well-funded, efficient public coverage system. Without additional resources, these losses in coverage put a strain on the public insurance system as it strives to keep more children from becoming uninsured. Unfortunately, given current

investments, the result has been that more children have become uninsured. Clearly, it is time to rethink these choices and become more serious about expanding public insurance.

The evidence is clear. Public insurance has been found to have significant positive effects on children's health. Expansions in public insurance for children have been associated with substantial reductions in child morbidity and mortality. Currie and Gruber (1996) find that the Medicaid expansions which doubled eligibility between 1984 and 1992 led to significant increases in doctor's visits and decreases in child mortality.

Enrollment in New York's SCHIP was associated with improvements in care for asthma, including access to medical care, quality of care, and asthma-specific outcomes (Szilagyi 2006). The results of Iowa's Separate State Health Insurance Program (S-SCHIP) show improvements in access to medical care, specialty care, dental care, preventive care, and increases in overall health status (Damiano 2005).

Similarly, enrollment in Missouri's SCHIP had a significant impact on child functioning and school performance (Behavioral Health Concepts 2002). In addition, children of mothers with public insurance during pregnancy have similar reductions in mortality as those with privately insured mothers when compared to those with uninsured mothers (Moss and Carver 1998).

In California, the effects of Healthy Families had equally striking positive results for children. California's public insurance program was found to improve access to health care services and improve health for children who were in the poorest health at time of enrollment (Healthy Families 2002). This research also found that children enrolled in Healthy Families missed school less and improved their overall school performance.

What are the policy options in California?

Democrats and Republicans alike have expressed a strong interest in insuring all Californians, especially children. Governor Schwarzenegger said, "I am committed to ensuring California leads the way in reducing the number of uninsured children" (Freking 2007). While the proposed approaches differ, the overarching goal is the same: that children have a fundamental right to health insurance. This would best be served through an efficient and reliable source.

According to the Institute of Medicine Guidelines for Reform, health care coverage should be universal, continuous, affordable, sustainable, and should enhance health and well-being (IOM 2004). California is 12% of the United States population but has unique demographic issues. It faces higher than average immigration, inequality, diversity, and it is characterized by a large contingent and informal labor market; all of these factors speak to the difficulty of a one-size-fits-all employment-based health insurance system. These issues should be taken into account when considering health reform options for California.

While employment-based coverage has fallen for all Americans—especially children—it remains the predominant source of coverage for nonelderly Californians. For those lucky enough to have high-quality coverage through the workplace, there is no reason to encourage employers to get out of the game. In fact, there are many reasons to keep them engaged, including worker satisfaction and continued reliability and efficiency. For small employers, employment-based coverage is often costly and subject to high variability in costs from one year to the next. For individuals and families experiencing long- or short-term spells out of the labor force, adequate health insurance is often out of reach. A health insurance solution should offer efficient and affordable options for all.

The vast majority of the nonelderly population is in families that work (Hacker 2007). Therefore, it seems natural to build on the best of the employment-based system and require employers to provide insurance to their workers and families or to offer them an affordable option outside of employment. The reforms proposed by presidential candidates John Edwards and Barack Obama at the national level, and those passed in Massachusetts and offered by Governor Arnold Schwarzenegger at the state level, all retain an important role for employers, referred to as "pay-or-play mandates." Requiring all employers to participate by either providing adequate coverage or contributing to the costs of similar

coverage serves to level the playing field between competing firms. It puts all employers, whether currently providing insurance or not, in the game of guaranteeing this valuable workplace benefit.

While the proposals all have a similar "play" component with varying standards of quality insurance, where they primarily differ is in the "pay" aspect of the employer requirement. Using substantial but not hardship-inducing contributions from firms, the most efficient solution is to default workers and families without high-quality workplace coverage into a large public insurance pool. For some firms, particularly small employers, this would offer a lower-cost solution to insuring their workers.

The reason why employment-based coverage for large employers has been so successful is that the larger the group being insured, the more efficient the provision of insurance. Per person administrative costs are far lower in the group market than the individual, private-purchase market. Notably, Medicare touts the lowest administrative costs and has been the best at restraining costs over the long run (Medicare Payment Advisory Commission 2005). Similarly, Medicaid's administrative costs are about half those of private coverage (Ku 2007). The largest of employers are able to spread risks across the entire group, sharing the burden of any worker's high health costs in a given year over many people. Since insurance is intended to shield individuals from high and unpredictable medical costs, sharing this responsibility over a large group (large employer or public plan) ensures reliability and sustainability of coverage.

Pushing workers and their families into the individual market has the opposite effect. A focus on individual rather than shared responsibility has real consequences for individuals when they seek insurance on their own. Privately purchased insurance on the individual market involves individual risk rating, where the less healthy can either be priced out of the market, denied coverage altogether, or offered coverage with stipulations that limit reimbursement for treatment of conditions they need it for most. Even if an individual is healthy and insurable one year, they or a family member may get sick the next year and become ineligible for continuous coverage. This lack of reliability and affordability makes the individual market risky and expensive for many. A long-term solution that pools risks is more efficient and sustainable over time.

As illustrated in this brief, it is increasingly important to push back against the unraveling of the employment-based system as families, communities, and businesses run better with an insured population. Pay-or-play mandates will increase overall coverage rates, level the playing field among employers, and expand shared responsibility. Providing a large public pool as the default "pay" plan ensures affordable and high-quality coverage and takes advantage of the efficiencies gained by large risk pooling and the cost savings, reliability, and sustainability it entails.

In the current environment, there looms a large problem of uninsured kids with growing losses in employment-based coverage and public programs demonstrably underfunded. In the near term, employment-based coverage and public insurance can be seen as partners, working together to close the gaps in coverage. In the long run, these different coverage mechanisms could compete to become more efficient and cost effective in the provision of insurance. Research indicates that a public solution may be less expensive and just as effective in providing children with access to health care as private insurance (Ku 2007). The long-run solution should take from the best of both and ensure that all children have high-quality, affordable health coverage.

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Endnotes

1. The California Health Interview Survey (CHIS) is often used to analyze health insurance information in California. It has a larger sample size for California than the CPS and allows more in-depth study in certain areas. However, the CHIS is only performed every other year, does not offer the same historical data as it only began in 2001, and its data are less recent. In addition, the CPS is a nationwide survey that provides useful comparisons between California and national numbers.
2. For this analysis, I line up people in families with children by their total family income and put them into five equal groups from the lowest income fifth to the highest income fifth. Then, using the income cutoffs for each quintile, I assign children into each group. Because of the negative correlation between income and number of kids, more children are found in lower quintiles than in higher. This follows the methodology used by the Congressional Budget Office and other government agencies.
3. Hoffman and Gaskin (2001) estimate the average cost of an avoidable hospital stay in 2002 to be $3,300. Here, that number is updated to 2006 using the Consumer Price Index for Medical Care.
4. The California data were far too volatile to display in a meaningful way year by year, however, the overarching results are consistent with the national picture.

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